Chronic Condition Health Home Policy Framework

August 2016

Today's Presentation

1. Introductions
2. Background on the CMS Health Home Model
3. The District's Health Home Goals and Overview
4. Beneficiary Eligibility
5. Provider Eligibility
6. Payment Approach
7. Health IT
8. Questions/Discussion

Health Home Overview

MODEL:

- Providers integrate and coordinate all primary, acute, behavioral health, and long-term services and supports
- Must include FFS and MCO beneficiaries
- CMS provides 90/10 match for the first 8 quarters

ELIGIBILITY:

- Have 2 or more chronic conditions
- Have 1 chronic condition and are at risk for a 2nd
- Have one SMI

REQUIRED SERVICES*:

- Comprehensive care mgmt.
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support

*See Appendix B for definitions

Goals for Health Home 2 (HH2)

- Improve the integration of physical and behavioral health care
- Reduce healthcare costs
  - Lower rates of avoidable Emergency Department use
  - Reduce preventable hospital admissions and re-admissions
- Improve the experience of care and quality of services delivered
- Improve health outcomes

Proposed HH2 Overview

- **Target population:** ~25,000 beneficiaries (~2/3 FFS)
- **Eligibility:** 3 or more chronic conditions
- **Enrollment***: Patients will be assigned to a HH2 provider through an opt-out, with utilization trigger process. Patient attribution to HH2 provider will be based on a prior provider/patient relationship (up to a 2 year look-back), geography, provider capacity
- **Target Start Date:** April ‘17

*See Appendix A for a beneficiary-centric enrollment/attribution flow diagram

Medicaid Chronic Conditions by Prevalence and Cost

Health Home-Eligible Chronic Condition	Top 20 Chronic Conditions, Prevalence	Top 24 Chronic Conditions, Cost (Associated with Top 1% of Spenders)
Asthma/COPD	Y (#3)	Y (#16)
Cerebrovascular Disease	Y (#15)	Y (#6)
Congestive Heart Failure	N	Y (#8)
Chronic Renal Failure (Dialysis)	N	Y (#7)
Conduction Disorders/Cardiac Dysrhythmias	Y (#17)	Y (#18)
Diabetes	Y (#4)	Y (#3)
Hepatitis	N	N
HIV	N	Y (#13)
Hyperlipidemia	Y (#2)	Y (#10)
Hypertension	Y (#1)	Y (#1)

Health Home-Eligible Chronic Condition	Top 20 Chronic Conditions, Prevalence	Top 24 Chronic Conditions, Cost (Associated with Top 1% of Spenders)
Malignancies	N	Y (#24)
Myocardial Infarction	N	N
Obesity	Y (#6)	N
Paralysis	N	Y (#5)
Peripheral Atherosclerosis	Y (#13)	Y (#12)
Pulmonary Heart Disease	N	Y (#22)
Sickle Cell Anemia	N	Y (#23)
Depression	Y (#5)	Y (#11)
Personality Disorders	Y (#8)	Y (#14)
Substance-Use Disorders	Y (#14)	N

HH2 Provider Enrollment

A. Eligibility Standards:

- Be enrolled as a DC Medicaid provider;
- Not have current or pending exclusions, suspensions or debarment from any federal or DC healthcare program; and
- Maintain compliance with the Enrollment and Maintenance Standards

B. Enrollment Standards:

- National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) Level 2;
- Certified electronic health record (EHR);
- 24/7 access to clinical advice;
- Hospital and ER alerts for enrolled individuals (i.e. CRISP Health Information Exchange (HIE) alerts)
- Staffing model of qualified persons, that fill the following roles for each acuity group of HH beneficiaries or offer alternative staffing model of comparable staff:
- Demonstrate ability to:
  - Deliver core HH services, as well as document the services;
  - Directly provide, or subcontract for the provision of, HH services; and
  - Establish and maintain communication protocols with external health care partners.

Suggested Staffing Model

Team Role	**Group 1, Lower Acuity** (3 or more conditions)	**Group 2, Higher Acuity** (3 or more conditions + risk score)
Nurse Care Manager	Ratio 1:400 Beneficiaries	Ratio 2:400 Beneficiaries
Care Coordinator/Bachelor Social Worker		Ratio 2:400 Beneficiaries
Peer Navigator/Community Health Worker	Ratio 1:400 Beneficiaries	Ratio 3.5:400 Beneficiaries
Clinical Pharmacist		Ratio 0.5:400 Beneficiaries
Health Home Director	Ratio 1:400 Beneficiaries	Ratio 1:400 Beneficiaries

Proposed Payment Approach

- **Payment Approach:** HH providers must deliver at least 1 HH service within the calendar month in order to receive a PMPM that month. In order to receive the first PMPM payment, a HH provider must:
  - Inform the HH beneficiary about available HH services,
  - Receive the beneficiary's consent to receive HH services,
  - Begin the development of a care plan.

- **Payment Groups**
  - Group 1 = 3 or more chronic conditions
    - $46 PMPM
    - ~20,000 beneficiaries
    - HH service does not need to be delivered in-person
  - Group 2 = 3 or more chronic conditions + higher likelihood of future hospital utilization based on a risk assessment
    - $137 PMPM
    - ~5,000 beneficiaries
    - At least 1 HH service needs to be delivered in-person

- **Pay-for-Performance**: At a later date, a P4P element will be added for HH2 providers who meet set metrics on readmission, preventable inpatient, avoidable ED utilization

HH2 HIE/Data Infrastructure

- Utilize a certified EHR.
- Enroll in CRISP to receive hospital event alerts.
- Pending federal funding, HHs will also have access to
  - A *Dynamic Patient Care Profile tool*; an "on-demand" document made available to Meaningful Use Eligible Providers and Eligible Hospitals, in addition to members of the care team, that would display an aggregation of critical data (both clinical and administrative) for a selected patient.
  - An *Electronic Clinical Quality Measurement Tool and Dashboard*, an electronic clinical quality measurement tool to route inbound CCDs from eligible Medicaid hospitals and practices to support required quality calculations and reporting; develop a population-level dashboard accessible by EPs and EHs for patient panel management.
  - An *Analytical Patient Population Dashboard*, also being developed with support from IAPD funds to enable EPs and EHs to perform panel-level analysis on their associated patient populations.

APPENDIX A

Meet Robert

- Robert is a 30 year old DC Medicaid beneficiary and has been diagnosed with HIV, hypertension, heart disease, asthma, and diabetes
- Robert has had 6 ED visits and 3 IP visits in the last 2 years
  - 4 of the ED visits were related to his unmanaged diabetes
- Robert has a primary care provider (Dr. Smith) at an FQHC (DC Clinic)
  - DC Clinic has limited resources and currently provides limited care coordination services; however DC Clinic is enrolling as a HH provider
- Robert has also occasionally visited another primary care provider (Dr. Williams) at a local physician's office (Washington Physicians)
  - Washington Physicians is not enrolling as HH provider

Robert's HH Enrollment: Overview

DHCF Runs Claims to **Determine Eligibility**

DHCF **Auto Assigns** Robert to DC Clinic's Panel

Payment triggered when Robert receives first HH service from DC Clinic

Robert Can **Opt-Out**

Robert Can **Switch** HH Providers

Robert's Notification of HH Program & Attribution

Robert receives **notification** from DHCF about HH program and HH attribution to DC Clinic

Notice to Robert **clearly communicates** information on the opt-out process, that HH services are free, that enrollment is optional, and that not enrolling does not impact current services

DHCF notifies DC Clinic and Washington Physicians about Robert's assignment to help ensure Robert is receiving consistent information from his network of providers

Robert will receive outreach from DC Clinic to initiate the **informed consent** process and begin the development of **comprehensive care plan**

Robert's Receipt of One of the Six HH Services

DC Clinic schedules an appointment with Robert where he receives comprehensive needs assessment and DC Clinic develops person-centered, continuous, and integrated **HH care plan**

Robert's care plan is created and updated in DC Clinics' **EHR**

DC Clinic refers Robert to a **smoking cessation program** and provides follow-up support as part of the execution of his care plan

Robert's Health Status is Being Monitored Regularly

Daily DC Clinic will review hospital ADT feeds to determine if Robert used the ER or was admitted to the hospital

Weekly DC Clinic huddles to track progress and plan accordingly for interventions/interactions

Monthly DC Clinic reviews registries and care plan status; if there are emerging issues warranting changes, Robert should anticipate follow-up up (e.g. re-assessment, revised/increased levels of activity)

Robert's Acuity Status Change

Robert can be moved to a different tier due to **status change**

Robert's initial **risk score** put him Group 1.

In year two of the HH program risk scores are run again; based on the new score, Robert is now **moved to Group 2**

Robert Decides to Opt-Out

Robert decides to **opt-out**

DC Clinic informs DHCF that Robert opted-out

Robert can also **inform DHCF** that he wants to opt-out

This opt-out request automatically **triggers outreach** from DHCF to explain the program/ inform Robert of other HH providers

Robert Decides to Change Providers

Robert decides to **change HH2 provider**

Washington Physicians has become a HH provider and Robert wants to switch

Washington Physicians **informs DHCF** that Robert has switched providers; Robert is taken out of DC Clinic's panel

APPENDIX B

Proposed Comprehensive Care Management Definition

- **Comprehensive care management** (CCM) is the creation, documentation, execution, and updating of a person-centered plan of care. CCM services address stages of health and disease to maximize current functionality and prevent individuals from developing additional chronic conditions and complications. These services include, but are not limited to conducting a comprehensive biopsychosocial needs assessment to determine the risks and whole-person service needs and lead the HH team through the collection of behavioral, primary, acute and long-term care information from all health and social service providers (e.g. from existing MHRS Diagnostic Assessments and individual service plans; physical assessments from other PCPs; hospital discharge planners; etc.) to create a person-centered, continuous, and integrated HH care plan for every enrolled individual.
  - HHs will use a strengths-based approach in developing the HH care plan that identifies the positive attributes of the individual, which includes assessing his/her strengths and preferences health and social services, and end of life planning.
  - Each HH team will update the care plan for each empaneled individual at set intervals, whenever there has been a significant change in condition, and following an unplanned inpatient stay.
  - The HH team will monitor individual's health status, engage the individual in HH services and their own care, and progress toward goals in the care plan documenting changes and adjusting the plan as needed.
  - The HH care plan is created and updated in the HH's certified EHR technology, along with documented activities completed to create and maintain the HH care plan.

Proposed Care Coordination Definition

- **Care coordination** is the implementation of the HH care plan through appropriate linkages, referrals, coordination and follow-up to needed services and support. Care coordination may involve:

  - appointment scheduling and providing telephonic reminders of appointments;
  - assisting the individual in navigating health, behavioral health, and social services systems, including housing as needed;
  - community-based outreach and follow-up, including face-to-face contact with individuals in settings in which they reside, which may include shelters, streets or other locations for unsheltered persons;
  - telephonic outreach and follow-up to individuals who do not require face-to-face contact;
  - ensuring that all regular screenings are conducted through coordination with the primary care or other appropriate providers;
  - assisting with medication reconciliation;
  - assisting with arrangements such as transportation, directions and completion of durable medical equipment requests;
  - obtaining missing records and consultation reports;
  - encouraging the individual's decision-making and continued participation in HH care plan;
  - participating in hospital and emergency department transition care;
  - documentation in the certified EHR technology; and
  - ensuring that individual connects to systems of eligibility for public benefits, including Medicaid

Proposed Health Promotion Definition

- **Health Promotion** is the provision of health education to the individual (and family member/significant other when appropriate) specific to his/her chronic illness or needs as identified in his/her HH care plan.
  - Assistance with medication reconciliation and provides assistance for the individual to develop a self-management plan, self-monitoring and management skills and promotion of a healthy lifestyle and wellness (e.g. substance abuse prevention; smoking prevention and cessation; nutrition counseling; increasing physical activity; etc.).
  - Health promotion may also involve connecting the individual with peer/recovery supports including self-help/self-management and advocacy groups, providing support for improving an individual's social network, and educating the individual about accessing care in appropriate settings.
  - . Health promotion may also involve the assessment of the individual's understanding of their health conditions and motivation to engage in self-management, and using coaching and evidence based practices such as motivational interviewing to enhance understanding and motivation to achieve health and social goals.
- HH team members will document the results of health promotion activities (e.g. individual requesting additional nutrition counseling; individual selecting a date to quit smoking; successful linkage with a community-based support group) in the individual's care plan, and ensure health promotion activities align with the individual's stated health and social goals.
- Each HH will use data to identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions, and modify them accordingly.

Proposed Comprehensive Transitional Care Definition

- **Comprehensive transitional care** is the planned coordination of transitions between health care providers in order to reduce hospital emergency department and inpatient admissions, readmissions and length of stay. These services include, but are not limited to efforts that:
  - Increase individual's and family members' ability to manage care and live safely in the community, shifting the use of reactive or emergency care and treatment to proactive health promotion and self-management.
  - Automatically receive notifications of emergency room visits, admissions, discharges and transfers (ADT) from hospitals as part of HHs' enrollment in CRISP, and will outreach to the hospitals individuals related to these notifications to ensure appropriate follow-up care
  - Conduct in-person outreach when the individual is still in the hospital or call the individual within 48 hours of discharge.
  - Schedule visits for individuals with a primary care provider and/or specialist within one week of discharge.
  - Have a clear protocol for responding to ADT alerts from hospitals or any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care.
  - As part of consumer contacts during transitions, the HH will: a) review the discharge summary and instructions; b) perform medication reconciliation; c) ensure that follow-up appointments and tests are scheduled and coordinated; d) assess the patient's risk status for readmission to the hospital or other failure to obtain appropriate, community-based care; e) arrange for follow-up care management, if indicated on the discharge plan; and f) plan appropriate care/place to stay post-discharge, including facilitating linkages to temporary or permanent housing and arranging transportation as needed for transitional care and follow-up medical appointments.

Proposed Individual and Family Support Definition

- **Individual and family support** Individual and family support services are activities that help the individual and their support team (including family and authorized representatives) in identifying and meeting their range of biopsychosocial needs and accessing resources. These services include, but are not limited to medical transportation; language interpretation; appropriate literacy materials; housing assistance; and other benefits to which they may be eligible or need.

  - Provide for continuity in relationships between the individual/family with their physician and other health service providers and can include communicating on the individual and family's behalf.
  - Educate the individual in self-management of their chronic condition; provide opportunities for the family to participate in assessment and care treatment plan development; and ensure that HH services are delivered in a manner that is culturally and linguistically appropriate.
  - Includes referrals to support services that are available in the individual's community and assist with the establishment of and connection to "natural supports."
  - Promote personal independence; assist and support the consumer in stressor situations; empower the consumer to improve their own environment; include the individual's family in the quality improvement process including surveys to capture their experience with HH services; and allow individuals/families access to electronic health record information or other clinical information.
  - Where appropriate, the HH will see the whole family as the client, developing family support materials and services, including creating family support groups.

Proposed Referral to Community and Social Support Definition

- **Referral to community and social support** is the process of connecting beneficiaries with referrals to a wide array of support services that will help them overcome access or service barriers, increase self-management skills, and achieve overall health. These services include, but are not limited to:

  - Facilitating access to support and assistance for individuals to address medical, behavioral, educational, economic, social and community issues that may impact overall health. For persons experiencing homelessness, this support may include individual housing transition services, as described in the June 26, 2015 CMCS Informational Bulletin
  - The types of community and social support services to which individuals will be referred may include, but are not limited to: a) wellness programs, including smoking cessation, fitness, weight loss programs; b) specialized support groups (e.g. cancer; diabetes support groups; etc.); c) substance treatment, support groups, recovery coaches, and 12-step programs; d) housing resources, including additional housing and tenancy sustaining services; e) social integration; f) financial assistance such as TANF or Social Security; g) Supplemental Nutrition Assistance Program; h) employment and educational program or training; i) legal assistance resources; j) faith-based organizations; and k) child care
  - HHs will assist in coordinating the services listed above, facilitating linkages and helping address barriers to accessing services, and following up with individuals to ensure that needed services have been received.
  - The HH will develop and monitor cooperative agreements with community and social support agencies in order to establish collaboration, follow-up, and reporting standards and provide training and technical assistance as needed regarding the special needs of the population.